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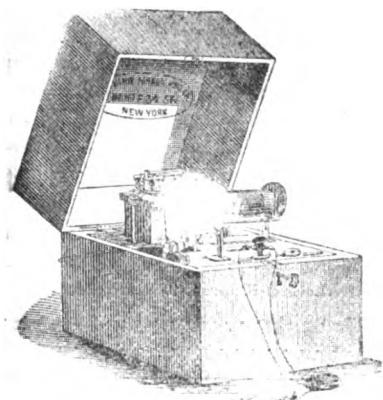
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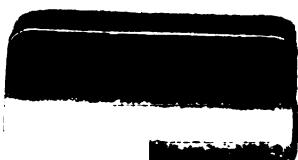
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# KANSAS CITY MEDICAL JOURNAL.

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## Original Communications.

### Reflections on Erysipelas.

By J. F. HANNA, M. D., Ashley, Mo.

A disease which attacks persons of all ages and of either sex, without discrimination, and which is liable to make its appearance at any and all seasons of the year, sometimes in a form so mild as to render the patient, *not sick*, but merely indisposed, at others, in so severe a form, as to entitle the patient to the appellation, *alarmingly ill*, (and sometimes the results are so direful as to prove this expression too sadly true,) cannot fail to be of interest and importance to every humane and intelligent practitioner of the Healing Art.

That Erysipelas is such a disease, none who have observed, studied and treated it, can truthfully deny.

In this paper, gentlemen, I shall not write down a history of the disease, as detailed by various authors on the practice of medicine, but shall, in my poor way, present to you such views as I have formed, first, by studying, somewhat, of what has been written on the subject, and second, from what I have observed at the bed-side of country patients, while carefully watching the course of the disease, and trying intelligently and rationally to treat it.

I am slow to call it an inflammation, and yet for want of something more expressive of what I regard its true nature, I suppose I will have to; for if it is true that redness, pain, heat and swelling, are pathognomonic of inflammation, and that a return to health of the parts involved, by resolution; or death of the same, by suppuration, ulceration or gangrene, are legitimate consequences of inflammation, then it follows that erysipelas is essentially an inflammation.

It is, certainly, a strikingly peculiar inflammation; its name indicates one of its

peculiarities, derived from two Greek words signifying "I draw in," and "near," referring to its inclination to spread. It almost always attacks parts adjacent, and sometimes, despite our best directed efforts to arrest its onward march, traverses nearly the whole body of the patient. In addition to its very universal tendency to spread, there is for the most part, a well defined line between the affected and healthy structure, the former being elevated and tender to the touch, so much so, that it is not infrequently the case, that the practitioner can trace the extent of the local trouble, unaided by the eye, using only the sense of touch. It is scarcely necessary to say, that the affected part, with the tumefaction, has increased redness and heat and very often a burning pain.

This redness, varying from a bright scarlet to a dark purple or livid hue, according to the duration and severity of the attack, stops abruptly with the limit of the swelling, and is not gradually lost, in the surrounding healthy structure, as is the case with an ordinary, externally inflamed surface.

We have then, here, a disease denominated an inflammation, presenting these three peculiarities, viz.: a tendency to spread, a well defined line between the healthy and diseased structure, (this line caused by the elevation of the diseased part) and the discoloration ceasing abruptly with the tumefaction, so far as the boundary is concerned.

Now the question in my mind is, what causes this inflammation to assume these peculiarities? Is there any morbid condition or conditions, of either the fluids or the solids, known by etiologists, to be productive of just such results? I know not. The common division of causes into predisposing and exciting, is appropriate in this disease. I am pretty fully persuaded, the predisposition is induced by a morbid condition of the blood, but what that morbid condition is I frankly confess I am unable, with certainty, to determine.

Anæmia, alone is insufficient to produce it; for we have seen hundreds of anæmic patients who have never suffered from erysipelas. The same may be said of plethora.

We are taught that in active inflammation there is too much fibrin in the blood, and in typhoid fevers, or continued fevers of that type, there is too little. Now we all know, it frequently occurs in erysipelas, that we have a violent local inflammation, with a fever of a well marked, low grade from the onset; hence we infer that anæmia, plethora, hyperniosis or hypnosis, taken singly, are insufficient for the production of the predisposition in question; and it is not at all certain, that any two of these morbid conditions of the blood, simultaneously existing, would produce it. The blood is subject to numerous other changes than those mentioned; there may be a deficiency or an excess of fats, extractive matter, salts and albumen, thus rendering the liquor sanguinis, in a measure, useless or injurious. A combination of two or more of these morbid states of the blood *may* act as the chief agents in the production of this predisposition. I am very much inclined to the opinion, that abnormality, qualitatively or quantitatively, or both, of the albumen of the blood, has much more to do in this matter, than that of any one constituent of the blood; and my reasons for *this* conclusion are, *first*, the serum of the blood owes much of its density to the albumen it contains, and *second*, we learn from physiologists, that there is reason to believe, albumen furnishes the pabulum for the development and renewal of the corpuscular elements of the blood.

I think there is reason for believing, *there is* deficiency in the corpuscular elements of the blood; a deficiency in quality or quantity, or both, and I am strengthened in this belief by the action of the remedy that has, in my hands, proved most successful in the treatment of this disease, as I shall notice hereafter.

The predisposition established, the local trouble may be set up by numerous and varied causes, which are appropriately enough termed *exciting causes*, and when these are the result of a wound, whether incised, punctured, or lacerated, the disease is termed traumatic, and when the exciting causes are obscure or not certainly known, it is said to be idiopathic.

The topical trouble I regard as a local manifestation of a constitutional disease; and the system becomes predisposed to the disease, chiefly through the agency of unhealthy blood; hence I conclude, that whatever tends to deteriorate the blood, or to bring about an abnormality of any one or more of its constituents, does much to render the patient liable to an attack of erysipelas, which may be developed by an exciting cause of the most trivial sort.

I doubt the contagiousness of erysipelas. In my own experience I have no reason for thinking it so; yet since high authority tells, and I don't doubt it, that it is transmissible by inoculation, it would be well for us, in our practice, to act as though it were contagious, lest by our appliances, our hands or instruments, we become the propagators, rather than the healers, of disease.

I have nothing to say of epidemic erysipelas, or of that very fatal variety which occurred years ago in various portions of the United States, and was designated in common language, "Black Tongue."

The local trouble is very often preceded by a feeling of lassitude, want of appetite and general indisposition; the patient will express it, "I am hardly sick enough to take my bed, and too sick to do anything." He feels that there is something the matter, but can't describe it. We in the country hardly ever see the patient until he himself discovers the local trouble. In the oedematous variety, this is characterized by a slick, glossy appearance of the affected part, no great redness, but often considerable swelling, which pits on pressure. In this variety, I have never seen the constitutional symptoms at all severe. In the simple form the discoloration is quite considerable from the beginning. It, sometimes, starts with a red pimple, resembling somewhat a small boil; as it spreads the surface is sometimes covered with small vesicles, which discharge an acrid and irritating fluid; at others, it presents a shining glossy appearance. The redness varies from a bright scarlet to a dark purple. The pain in this variety is considerable, sometimes lancinating, but oftener of a burning sort. At first, the fever is often slight, only a febrile tendency; but generally, unless the disease is promptly arrested, the fever and concomitant symptoms increase, varying in their nature, in accordance

with the type of the fever, one set of symptoms and functional disturbances, if the fever is of the remittent type, and another and more to be dreaded set, if the fever is of the continued form, and especially if it assumes the typhoid livery.

The symptoms present in these grades of fever, from the slightest to the most grave, are too well known to require to be given in detail in a paper for an occasion like the present.

The phlegmonous variety is characterized by an involvement of the deeper seated structures, and of course as a general rule, by a graver set of constitutional symptoms. Phlegmon, I believe, means an inflammation of the cellular tissue, but I have seen the skin, superficial fasciae, cellular tissue, muscle, and in one case tendon, seriously involved in this variety of erysipelas. In children, this variety may exist for several days before it can be detected by any local trouble, because the child can't always designate the point, or character, of the soreness; nor is this strange, when we remember that it is sometimes the case with adults, they are unable to give the practitioner any definite idea of the character of the pain, or he is too obtuse to detect it, until suppuration takes place. I mean to say that this variety sometimes starts in the deep seated structures, and then it requires the closest scrutiny on the part of the doctor to diagnose it correctly before it makes an open, external appearance. The discoloration in this variety is of a more livid hue, and in this dark tint the peculiar glossy appearance, of the other varieties, is, in a great degree, lost.

The inflamed surface, when it reaches the surface, loses the elasticity that belongs to the simple variety. Often, on pressure persistent for a few seconds, there is a peculiar doughy feel, with pitting, indicating, as I think, the existence of deep seated matter. The pain is very great, so much so as to exert a great influence in tearing down the constitution of the patient. It has never been my misfortune to meet with a case where gangrene, with its death train of symptoms, appeared, to render more terrible this fearful disease.

From the nature, symptoms and pathology of this disorder, it is very evident the treatment must be constitutional as well as topical. What is generally termed an active

antiphlogistic treatment, I deem useless, and in a large majority of cases really injurious. Blood letting, emesis and purgation may (?) accomplish much, in some inflammations, but are unsafe and uncalled for in this peculiar inflammation. A laxative or purgative, as occasion may require, may be used to clear out the alimentary canal, and after that, as a rule, only as may be needed to produce an evacuation from the bowels daily or every second day.

Mr. C. Hamilton Bell, of Edinburgh, struck the key note, in the treatment of this disease, when he introduced the tincture of chloride of iron, as a reliable and trustworthy remedy, an account of which he published in 1851. I am accustomed to prescribe it in less doses than Mr. Bell, rarely directing more than ten drops every fourth hour.

I have learned to rely upon it, having never been disappointed in its use. No matter what the train of systemic symptoms, or what the character of the fever, whether continued, typhoid or remittent, it is important to keep up the iron. Delirium or stupor is no barrier to its successful use. The success which obtains from the use of iron, in the treatment of this malady, strengthens my view of its pathology, viz.: that the morbid influence giving rise to the predisposition to this disease, is found in a disordered condition of the blood. I am of the opinion that the restorative and invigorating effect, upon the blood, of the iron, and consequently its general tonic properties to the system, consist not alone in its furnishing haematin to the red corpuscles. I think it does much more.

But to return to the treatment, I will state that I regard sulphate of quinine a valuable adjuvant to the iron; hence I often direct from two to three grains with every dose of the iron, and if the fever is of the remittent type, it may be advantageously used more frequently and in larger doses. Pain must be alleviated by a judicious use of anodynes. I usually employ an opiate or some of the salts of morphine. I enjoin perfect quietude; direct that sleep shall be encouraged, and for this purpose sometimes use hyosciamus. Such palliatives as the course and nature of the case may demand, must be resorted to.

If a dry tongue and tender and tympanitic bowels exist, a turpentine emulsion is an excellent remedy. In this class of cases, I

have, occasionally, used calomel in one grain doses, thrice daily, to try to arouse the secretions. Diaphoretics and diuretics I have used sparingly, and with no decided favorable results.

In the phlegmonous variety, when we are certain there exists pus, even though it be deep seated, a large and free opening for its escape, is imperatively called for, both for our own reputation and the safety of the patient. When the vital powers are much exhausted, from *any* cause, I use milk punch pretty freely, and indeed I think it imprudent to put off the use of this remedy too long. In cases where suppuration has taken place, and the disposition to form pus becomes protracted, and especially if the patient is of a strumous diathesis, I advise the use of iodide of potassium, from which I have derived most excellent results.

I regard topical remedies, for the most part, more palliative than curative. I think the spreading tendency of the inflammation is often greatly lessened by the use of the tincture of iodine. I usually paint the affected part over, and also one-and-a-half or two inches of the well surface, twice or thrice in twenty-four hours. I prefer tincture of iodine to all other remedies for this purpose. I often direct slippery-elm mucilage to be applied to the inflamed part, by means of a folded towel kept continuously wet with it. A poultice of powdered slippery-elm and ground flax-seed makes an excellent sooth-ing application. When suppuration has taken place and an opening been made for the escape of the matter, the best application to favor its discharge is a ground flax-seed poultice.

In the simple variety, I have received great benefit from the use of a plaster made of molasses and flour. When the pain and soreness have been very great, this applica-tion has given entire relief, while many others have failed. It is an old woman's remedy, and I know nothing of its modus operandi, only from a happy and pleasant experience.

The use of carbolic acid hypodermically is favorably mentioned by Dr. Aufrecht, of Magdeburg. He uses it upon the ground that the spread of the disease is occasioned by organic bodies which penetrate the cellular tissue and then multiply, claiming that the acid is death to these organisms. He

used a one per cent. solution, administering about six decigrammes at once and repeating the operation twice daily. He injected the remedy into the sound cellular tissue, above the diseased surface. His experiments embraced two patients; and in one, four injections, and in the other, five were all that were necessary for a cure. I should like to hear of a larger experience of its suc-cessful employment before I would rely upon it, or accept, even, Dr. Aufrecht's theory of the propagation and spread of the disease.

#### Amputation of Tumors by the Elastic Ligature.

By J. D. GRIFFITH, M. D., Kansas City.

Jennie F. Age 35. Occupation seamstress. Intemperate. Had a chancre ten years ago, followed by a secondary and tertiary symptoms. Received a thorough course of mercury, according to her own statement, and was comparatively well up to about three years ago. At that time noticed on each labia minora, either side of the clitoris, small wart-like growths making their ap-pearance. These at first (for several months) did not cause any trouble or un-easiness. They continued to develope, and in the course of one year had arrived at the size of a small hen's egg, and the whole of the labia minora now began to be involved, the mass protruding above the labia majora. Continued to increase and become more and more solid.

July 10th, 1874. Was sent to City Hos-pital. She says that "every treatment (locally and constitutionally) that any one could possibly imagine has been tried, and nothing has reduced the size of the tumors."

**Examination:** Attached to either of the labia minora and protruding from the os-tium vaginae, are two large heterologous masses, firm and nodulated, the base of the tumors being somewhat pedunculated. The weight about four ounces each.

The elastic ligature was suggested as a means by which the tumors could be ampu-tated, the knife being unadvisable, on ac-count of the immense blood supply.

No solid elastic, as advised by Sir Henry Thompson, could be found. However, Dr. Day secured (from our wide-awake friend, F. Woher) a piece of small elastic tubing,

which would answer every purpose.

The patient having been put under the influence of chloroform, Dr. Day passed a sharp pointed bistoury through the centre of the base of the tumor, following with a bodkin probe armed with the elastic tubing, thus including one-half of one of the tumors in each ligature.

The tumor on the opposite side was treated in the same manner. Patient rallied from chloroform well. Complained of a good deal of pain about the tumors. Ordered Magendie's solution of morphine, M. xv, and lead and opium wash applied externally.

P. M. No pain. Tumors are dark purple. No sensation in them.

July 12th. No constitutional disturbance. Both of the tumors have dropped off, leaving a very small granulating surface.

July 16th. Patient well.

## Selections.

### On Nidation in the Human Female.

By J. H. AVELING, M. D.

Since our incomparable Harvey pointed out the resemblance existing between the womb and the nest, and menstruation and infecund oviposition, many writers have discovered other analogies, and have likened the change in the mucous membrane of the uterus preparatory to the reception of the ovum to the act of nidification in birds.\*

This peculiar function of the uterus has I believe been far too much neglected. Lying as it does between the acts of ovulation and menstruation, it has in a great measure been confounded with them, and has consequently not received that special consideration which its separate although correlative existence demands. Another reason why it has escaped attention is most probably to be found in the fact that hitherto this process has had no name applied to it. The similitude between it and the nesting of nest-making birds naturally suggested one of the three following words as the most appropriate—viz., Nidification, Nidamentation, and Nidation; the last appearing to be the most simple and sufficiently definite has been adopted.

**Definition.**—The act of nidation consists of the periodical development of the mucous membrane lining the interior of the body of the uterus.

\* "Both the Hen and Housewife are so matcht  
That her Son Born is only her Son Hatcht;  
That when her Teeming hopes have prosp'rous been,  
Yet to Conceive is but to Lay within."

Lines by Dr. Llewellen, prefixed to Harvey's Works.

**The nidal decidua.**—The membrane thus developed has received a great number of names. The one now most usually employed is menstrual decidua, but as it is formed independently of menstruation this is obviously a misnomer, and I have adopted as more appropriate that of nidal decidua. It is developed in the intermenstrual period, and immediately previous to the act of denudation attains in some parts considerable thickness. Its deep surface is intimately blended with the muscular structures, and its superficial surface is thrown into folds. It is not my intention to enter here into the consideration of its microscopical formation. This has been, and is still being, ably investigated. The latest paper on the subject being that of Dr. John Williams read before the Royal Society of London.

**Periodicity of nidation.**—Nidation being comparatively speaking an occult function, it is difficult to determine positively at what period of life it commences, how frequently it is abnormal in its character, or at what portion of the intermenstrual period it is most actively carried on. By frequent dissections, however, and more careful observation, these points may in time be very much elucidated. It most probably commences in an imperfect manner with the reproductive life of women, and recurs with regularity according to the periodic habit of the individual until that life ceases. During the week preceding menstruation it appears to proceed more energetically than at any other time. The supply of blood is then very large, and so altered does the uterus become in size and appearance that its hyperemic condition has frequently been mistaken for that resulting from pregnancy. The duration of the nidal period varies in different women. It usually continues three or four weeks, and corresponds with what has heretofore been called the intermenstrual period.

**Nidation and ovulation.**—Without an ovary there can be no reproductive life, and without this life there can be no nidation. So far, therefore, nidation is dependent upon ovulation for its being. Sexual life, however, once established, the existence and periodicity of nidation proceeds with an independence and individuality, the actuality of which is little appreciated.

The facts pointed out some time ago by Dr. C. Ritchie regarding the relations between ovulation and menstruation apply with equal force to those existing between ovulation and nidation. In spite of the destruction by morbid action or removal by operation of both ovaries, nidation is found in some cases to be continued. It also occurs when no ovum reaches the cavity of the uterus. In extra-uterine pregnancy, the nidal decidua is formed as it also is in the non-gravid half of a bicornate uterus.

**Nidation and impregnation.**—The relations existing between nidation and impregnation are but little known. Dr. Power, however, saw how far one must be dependent

upon the other. He says, "When the ovum is mature the uterus should be properly prepared for its reception. Any derangement in the equilibrium of this relation will tend to derange the subsequent steps of the process; thus, if the ovum is matured before the uterus is prepared for it the conception will be rendered abortive, et vice versa, the same effect will ensue if the uterus is too early prepared for the reception of the ovum." It seems certain that ova are discharged from the ovaries at irregular periods, and not as has lately been believed once a month at or near the time of menstruation. It is therefore an interesting question to decide at what period of nidation the uterus is in a most fit condition for receiving the ovum and permitting impregnation. Probably when the process of nidation is most active, insemination is impeded by the obstacles to the progress of the seminal fluid caused by the largely developed nidal decidua, and the increased secretion of tenacious cervical mucus. At this time the uterus is more particularly prepared for the reception of the ovum, which in an impregnated or unimpregnated condition may be slowly making its way down to the Fallopian tube. I have often observed that a sound will pass readily into the uterus at the commencement of nidation, and that it can scarcely be made to enter at its conclusion. It has been contended by some authors that nidation does not take place independently of impregnation. This hypothesis, however, cannot be maintained, for Mondat discovered the nidal decidua in two sterile women who had never menstruated, and Courte has removed it from the vagina of a girl whose hymen was perfect.

*Nidation and lactation.*—During the latter days of nidation a sympathetic hyperemic condition of the breasts is frequently observed. They become tumid and painful, and not unfrequently a thin milky fluid is secreted. When denidation has taken place all these conditions suddenly disappear, and the breasts again become softer and smaller, and lose their tenderness. After parturition, when lactation is fully established, the function of nidation is probably suspended; but it is speedily re-established when the nutritive demand of the breasts ceases.

Nidation has been likened to gestation. Denidation may be compared with parturition. The nidal decidua having reached its full development, and no impregnated ovum having arrived to demand from it protection and sustenance, a process of degeneration takes place, its attachments are loosened, and it is expelled by the contractions of the uterus, sometimes wholly in the shape of a triangular sac, but more frequently in minute portions. How long this process occupies has not been determined, but it is probably completed during the menstrual period.

*Denidation and menstruation.*—The act of denidation probably determines that of menstruation, because it is from the denuded surface of the uterus caused by the removal

of the nidal decidua that the menstrual flow comes. Power declares the efficient cause of menstruation to be, "an imperfect or disappointed action of the uterus in the formation of the membrane (decidua) which is requisite for its connexion with the impregnated ovum." He also says, "an improvement might be made upon the axiom that 'women who do not menstruate do not conceive,' by substituting 'a woman menstruates because she does not conceive.'"

I have no intention of ignoring the individuality of the menstrual nisus. Where no uterus exists and consequently no nidation, moliminal symptoms are observed, and blood issues from various parts of the body. It must, however, be admitted that denidation and menstruation are generally contemporaneous phenomena; and, although both may have separate existences, and the latter is not necessarily a sequence of the former, menstruation must in most cases be controlled in its periodicity by nidation. The relative values of the two acts are very widely different, for whereas nidation must be looked upon as a primary and important reproductive function, menstruation, as is well known, is secondary and insignificant. Many women become pregnant before menstruation, and others have borne children who never menstruated at all. The process of denidation is doubtless very much assisted by that of menstruation. By the menstrual flow the *debris* of the nidal decidua is floated and washed out of the uterus and vagina, and in this way the denidal act is rendered more prompt and effective.

*Painful nidation.*—Every gynecologist must have met with patients who suffer pains in the pelvic region, commencing a week or ten days previous to menstruation. In many it appears exactly a week before the period, and it continues with more or less intensity until the menstrual flow is fully established, when all suffering ceases. It cannot be doubted that this pain is due to nidation. It occurs in women having a chronic hyperemic condition of the uterus, which is doubtless increased by the afflux of blood necessary for the formation of the nidal decidua. Two hyperemias of morbid and physiological origin thus unite to produce the pain, weight, and numberless other sympathetic feelings so often met with.

*Hypernidation.*—The large afflux of blood just referred to, if it produces no pain will certainly have an influence upon the development of the nidal decidua. This intense hyperemy is the cause of that increase of its growth which ends in the production of the decidual sac, so tough as to resist the ordinary denidal disintegration, and to pass from the genital passage in an unaltered condition. Scanzoni had two patients who from their symptoms could always say with perfect certainty one or two weeks before the return of the menses, whether or not they would pass membranes. Power believed hypernidation to be due to increased ovarian

action. This may be one factor, but it is evident that every cause of uterine hyperemy, whether active or passive, must have the same tendency. It is a question whether excessive proliferation of the nodal decidua is not sometimes produced by what may be called *missed denidation*. Cases in favour of this view are not wanting. Women suffering from hypernidation are not necessarily sterile, for many cases have been observed, in which impregnation has taken place, notwithstanding the monthly expulsion of an unduly developed nodal decidua.

*Subnidation*.—There can be but little doubt but that in cases of serious disease and great weakness, the function of nidation, like that of ovulation and menstruation, is sometimes held in abeyance, and the nodal decidua is either not formed at all or is imperfectly developed. It is difficult to say what influence subnidation would have upon the menstruation, but it is easy to conceive what effect it must have upon fecundation. An impregnated ovum arriving in the uterus when unprepared by the nidatory process for its reception would very probably be aborted. Subnidation therefore must be looked upon as one of the causes of sterility. Dr. A. K. Gardner fully admits this. He says, "The defective or active formation of this uterine mucous membrane is most probably a frequent cause of sterility, especially if all the ordinary observable conditions of menstruation be present. An egg is discharged normally and may even be as regularly impregnated, but it meets no proper nidus in the uterus."

*Abortive nidation*.—There is, doubtless, a pathology of the nodal decidua, but this has yet to be studied. There is also probably such an accident as nodal abortion, capable of being produced by morbid, mechanical, traumatic, and physiological influences. This is another field for further investigation. What influence has it upon the too early recurrence of menstruation?

*Difficult denidation*.—The process of denidation may be divided into two periods, the separative and expulsive. What the disorders of the first are must for some time remain in obscurity, but the troubles attending the second stage have been known and appreciated for a long time. What has hitherto been called membranous dysmenorrhea is in reality a disorder of denidation (dysdenidation). In cases of hypernidation the uterus frequently experiences great difficulty in expelling the hypertrophied nodal decidua. It fills up the internal os and cervical cavity, and mechanically obstructs the fluid, producing pains as agonizing and continuous as those of childbirth. This difficulty is of course increased when any contraction or flexion of the uterine neck exists. Painful expulsion of the nodal decidua may also take place, independently of menstruation, as has been observed by Waller, who says,—"There is often no menstrual secretion, but in its stead a tough thick membrane, resembling

the tunica decidua of pregnancy, is discharged, the uterus acting forcibly, as in labour."

I will not here enter into the treatment of the disorders of nidation and denidation, but it must be evident to every one that no rational application of remedies can be used in these cases unless it is guided by a competent knowledge of their etiology. When it is necessary to operate in any way upon the cavity of the uterus, it must evidently be unwise to do so during the latter days of nidation, whereas depletion, as a rule, will be most required and effective at this period. Tents and stems when used should be inserted early in the nodal period.

When impregnation takes place denidation is postponed, and the nodal decidua continues to be developed in a manner so well known as to need no description here.

It may be broadly stated that denidation is always due to a cessation of the nutritive action subservient to reproduction. When the demand ceases the supply is withheld. In ordinary nidation the nodal decidua, having arrived at its normal development, degenerates, disintegrates, and is discharged, because no further demand is made upon it. The same occurs in gravidal denidation. A discontinuance of the claim upon reproductive nutrition is most commonly caused by the full development or death of the fetus. In either case denidation naturally follows. We have here, I think, a rational explanation of the determining cause of labour. Even in extra-uterine gestation, when the fetus dies or arrives at maturity, denidation takes place, and the nodal decidua is expelled with uterine pains simulating those of parturition. The analogy between the lochial and menstrual discharges has frequently been insisted upon.

Partial gravidal denidation artificially produced, is one of the best methods of inducing premature labour.

The foregoing lines present the reader with but a scanty syllabus of the subject of nidation. It is an imperfect, and often, I fear, an inaccurate sketch; but I hope soon to see its defects supplied and its errors corrected. I have endeavored to demonstrate the individuality and independence of the function of nidation, and its claim to a distinctive name and a special consideration. I have also striven to explain how important a part it plays in the progressive acts of reproduction, and that it should not be confounded with ovulation and menstruation, but be looked upon as a link connecting the two. The interest of the subject is intense. Sir J. Y. Simpson has rightly said,—"There are few circumstances, either in healthy or morbid anatomy, so strange as that the proper mucous tissue of the uterus itself may, within the compass of a menstrual period, form, enlarge, separate, and again be reproduced."—*Obst. Jour. Gr. Brit. and Ireland.*

### Fungous Origin of Erysipelas.

Dr. Wladimir Lukomsky publishes in *Virchow's Archiv*, Bd. 6 and Heft, 3 and 4, the results of certain researches on the origin and nature of erysipelas.

After some preliminary remarks on various modern views of the affection, Dr. L. gives notes of two series of cases, as well as of experiments made upon animals, etc.

His conclusions from the first series are as follows:

"The following facts," he says, "are established:" 1. The conclusions of other authors are confirmed, that severe and rapidly-spreading phlegmonous inflammation of the subcutaneous connective tissue, in which the cutis also takes a decided part, may be developed by the injection of fluids containing organic germs.

2. The micrococci multiply rapidly in the connective tissue, and spread principally through the serous canals and lymphatic vessels.

3. This inflammatory process may be brought about by a fluid containing organic germs which at the same time shows no signs of putridity, as for instance, fluids taken from living individuals. It follows from this that the existence of organic germs cannot in any way be regarded as a criterion of putridity.

4. Putrid (dead) fluids which do not contain micrococci and bacteria are not in themselves sufficient to bring about anything more than a local inflammation, which has no disposition to spread farther.

5. The contents of erysipelatous blebs free from organic germs cannot cause, where subcutaneously injected, any symptoms of disease.

From his second series of experiments Dr. Lukomsky draws the following conclusions:

1. Putrefying materials containing organic forms being placed in contact with a wound immediately bring about a severe local inflammation, which may also comprehend the surrounding skin. This wandering disease-process cannot be distinguished in its general symptoms from the so-called erysipelas occurring in human beings.

2. The micrococci and bacteria penetrate the connective tissue by means of the serous canals, and wander by these paths still farther.

3. They are found specially in the peripheric positions of the localized inflammation, and more particularly just where the inflammatory process is making most rapid progress.

4. Erysipelas moves preferably in certain directions. When, for instance, the wound in these investigations on animals lies in the middle line of the back or in its immediate neighborhood, the process spreads with equal rapidity on one side and on the other towards the abdomen, more slowly behind, and still more slowly forward.—*Phil. Med. Times.*

### Cholera.—Purging.

By J. S. BURNS, M. D., CHATTANOOGA.

I desire to call attention to the oft-repeated statement that, in some fatal cases of cholera, purging ceases several hours before death, and the abdomen becomes distended, the bowels no longer being able to expel their contents.

Flint says (page 427 of his *Practice*): "In some cases the evacuations, after several have occurred, cease; in other cases, after a time, the liquid flows away constantly, the patient being unable to prevent it."

Dr. F. K. Bailey, of Knoxville, in his interesting and instructive article which appeared in the April and May numbers of the *Journal*, incidentally alludes to the "cessation of the intestinal flow in the last hours before death, and quotes Dr. Sedgwick's statement: 'Purgings are apt to cease when collapse becomes intense, owing, no doubt, to inability of the bowels to expel their contents.'

Among the fatal cases that I observed during the epidemic of last summer, I do not recollect one in which purging ceased and the abdomen became very considerably distended, without its recurrence. As the liquid accumulates, the bowels are filled, and literally overflow, the paralyzed or torpid sphincter offering no resistance.

I was first led to make observations on this point by the following circumstance: I was called to see a patient who was sinking rapidly, but according to the statements of his attendants, had not had an evacuation for four or five hours. Doubting this, I caused an examination to be made, and discovered, plainly enough, an intermittent dribbling of serum, of which the patient himself was unaware.

In other cases, where the flow was less apparent, I proved its occurrence by having dry cloths applied, and finding them saturated. I followed this investigation from the early part of the epidemic to its close, with the result already stated.—*Nashville Journal.*

**CALIBRE OF HUMAN MALE URETHRA.**—Dr. Otis (*N. Y. Med. Journal*, April, 1874) says that, while the authorities fix a definite standard for the calibre of the urethra, there is, in fact, no such standard. A careful examination of several hundred urethras, by means of metallic bulbous sounds, has demonstrated to the doctor occasional extremes, varying from twenty to forty, and an average calibre of the male urethra of not less than thirty of the French scale, or eighteen of the English scale. The importance of this demonstration is seen by the light of the further statement, that the great majority of strictures, which are sources of grave annoyance, and call imperatively for treatment, are about what is set down by the French and English schools as worthy of consideration.

## Notes of Practice—Bellevue Hospital.

**SUPERIOSTEAL AMPUTATION OF THE TIBIA AND FIBULA.**—The patient upon whom this operation was performed entered the hospital suffering from an ulcer on an old stump. The history of the case was, that the patient had his leg amputated at the lower third. As a result of the operation, the anterior flap sloughed, leaving a cicatrix with an open ulcer over the extremities of the tibia and fibula, which showed signs of healing.

Dr. J. W. S. Gouley proposed to make a subperiosteal amputation of the bones, and in this manner compensate for the lost flap without the danger of a secondary amputation of the leg. The operation consisted in dissecting back all the tissues from the bones, and then separating the periosteum from them and reflecting it so as to leave an inch and a half of each of the bones bare. The exposed bones were then removed, the stumps being clothed by the periosteal flaps, and the whole being covered in by the soft tissues, forming a well-shaped stump. The case is doing well at present, being ten days since the date of the operation.

**ERYSIPelas; TREATMENT BY THE TAR METHOD.**—The tar-treatment has been introduced, on the assumption that erysipelas is communicated by means of germs, and an antiseptic like tar would be the most reliable method of stopping its propagation. The manner of using it is to keep the whole of the erysipelatous portions of the skin covered with tar, and in this manner render inert the emanations. The results so far obtained tend to prove that it is deserving of a more extended use.—*N. Y. Med. Journal.*

## ◆◆◆ Removal of Both Ovaries.

Mr. C. G. Wheelhouse, Surgeon to the General Infirmary at Leeds, reports (*British Medical Journal*, March 21, 1874) it has once fallen to his lot, on removing an ovary in the case of a young lady aged 19, to find that the other one was also in a state of incipient disease. This he removed at the same time, and thus perfectly unsexed his patient.

"It is three years ago this month since the operation was performed, and I have watched the case ever since with the greatest anxiety. There has never been any attempt at menstruation, nor has any vicarious discharge ever taken the place of the natural one; but, beyond this, I see no change of any kind. The general health is now as perfect as it ever was, and so far from any uncomfortable symptoms of masculinity having occurred, the voice remains as soft, the bust as full, and the whole aspect and demeanor are as perfectly feminine as in any other young lady of my acquaintance."—*Medical News and Library.*

## Action of Iodide of Potassium upon the Blood.

The reactions of the iodide of potassium, when administered medicinally, are thus described: In the stomach the iodide either undergoes no change, the elements of ordinary articles of food being incapable of decomposing it, or else by means of the chlorine hydriodic acid is formed, by which the ultimate reactions are not modified. Entering the circulation in an exceedingly dilute state, the iodide of potassium is at once decomposed by the superabundant carbonic acid into free iodine and carbonate of potassa. Now the iodine will have the greatest affinity for those substances in the blood with which it makes the most complex combinations, this affinity being most intense at the moment of the iodine becoming free. Therefore, of these substances in the blood those first acted upon would be the "miasmatic matters and ferments," next to these the fibrinous and then the albuminous substances, and last of all, the fats. The iodine acts upon these substances by virtue of its disposition to take the place of their component hydrogen. It, however, does not form permanent compounds with them, but, having broken up their chemical union, facilitates their oxidation in the oxygen of the blood. The free hydrogen combines with an equivalent of iodine, forming hydriodic acid, which is in turn attacked by the oxygen, iodine is again eliminated, and so the process is continued.

On the other hand, the other component of the iodide of potassium undergoes changes which supplement the action of the iodine. As the compound is decomposed the potash is changed into the hyperoxide of potassium, the only oxygen compound upon which the iodine does not act. Here we have, besides the iodine, a powerful decomposing agent, which, by its strong oxidizing effect upon organic substances, assists the consumption of the blood elements. The hyperoxide is reduced to potassum, which again combines with carbonic acid, and carbonate of potassa is produced as at first.

Hence the action of the iodide of potassium depends upon the decomposing effect of free iodine upon the substances contained in the blood, and their oxidation and consumption by the hyperoxide of potassium—"a result," the writer observes, "which is confirmed by clinical experience."—*Prof. Kammerer, Virchow's Archiv*, 1874, and *Memorabilien*, xix., 4.

## ◆◆◆ Final Experiments on the Elimination of Alcohol.

"Looking to the fact," says Dr. Anstie, in the *Practitioner*, "that Dr. Park and myself have from independent (and indeed opposite) quarters come to singularly close agreement as to the daily allowance of alcohol that can be taken without producing any narcotism

or other visible disturbance in the organism, I think I may take it as conceded that quite six hundred grains of absolute alcohol can be disposed of daily within the organism of an adult male, without any perceptible injurious effect upon the bodily functions. Now, this quantity of alcohol is (theoretically) capable of generating an enormous amount of force; but it is equally certain that that force does not show itself under the form of heat. It is scarcely possible but that the solution of the questions as to the action of alcohol in the body, will also bring about the discovery of new physiological facts of great interest and importance.

"1. If alcohol be a force-producing food, as seems by far the most likely, it is probably of great value in that capacity, on account of the rapidity with which its transformations take place. It is, however, abundantly certain that beyond a certain dosage (which is pretty clearly made out for the average, though of course there are individual exceptions in both directions) it becomes a narcotic poison of a very dangerous character in every respect; not the least disadvantage being that it cannot be eliminated to any considerable extent.

"2. If alcohol does not disappear by oxidation, it must undergo some as yet quite unknown transformation, after which it must escape unrecognized in the excretions. I have heard various attempts to suggest such modes of disappearance, but nothing so far which wears any air of probability.

"3. If alcohol, however, be indeed oxidized, and yet does not beget force which can be used in the organism, this would be the strangest possible discovery. Considering the very high theoretical force value of the six to eight hundred grains of absolute alcohol which millions of sober persons are taking every day, we may well be hopeless of any reasonable answer to the question, 'Why does not this large development of wholly useless force within the body produce some violent symptoms of disturbance?'" — *Amer. Practitioner*, Sept., '74

### A Practical Point in the Operation of Ovariotomy.

By DR. ATLEE, PHILADELPHIA.

Dr. Atlee calls attention to the following very important practical point in the operation of ovariotomy. It is this: *immediately after making the incision through the walls of the abdomen, the index finger should be passed up to the region of the umbilicus, and if it can be swept freely across from side to side it must be within the abdomen*. This, of course, is an easy matter when no adhesions exist. It is always possible, in parietal adhesions, when the finger is inside of the peritoneum. It is not possible, without the most unwarrantable violence, when the finger is between the layers of the abdominal parieties. The non-observance of this rule

has led to the separation of large portions of the peritoneal layer of the walls of the abdomen, even when no adhesions existed, the operator having mistaken the peritoneum itself for an adherent cyst-wall. When, however, parietal adhesions do exist, the mistake may be more excusable and more readily made, particularly in such a case as the one just related, where the peritoneum is thickened and more strongly incorporated with the cyst-wall than with the wall of the abdomen. The most convenient and infallible test of being within the abdomen is the ability to freely move the finger to and fro past the umbilicus.—*Phila. Med. Times*.

### Camphorated Phenol

Bufalini, in *Campagna Med. (London Medical Record)* describes the combination of camphor and phenol, and gives its therapeutic conclusions.

If equal parts of carbolic acid and camphor be dissolved in alcohol, and the mixture be allowed to stand for thirteen hours, a yellowish, oily stratum arises to the surface. This will not mix with the water or liquid, nor is the camphor precipitated by the alcohol. This substance is called camphorated phenol. It is best prepared as follows: One part of carbolic acid and two of camphor are mixed in a vessel and allowed to stand for some hours. A reddish-yellow oily liquid will be formed, which is to be purified by washing with water. The properties of this combination are reddish-yellow color, oily appearance, smell of camphor, insoluble in water, but soluble in alcohol and ether. From considerable experience in its use, Bufalini concludes:

(1) Camphorated phenol produces the same effects as carbolic acid, but is less dangerous. It may be used both externally and internally, viz: in enteric fever, etc.

(2) It has the power of modifying unhealthy wounds and of destroying the parasites which are present in certain diseases, as septicæmia, typhoid fever, etc.

(3) The medical use of camphorated phenol is to be preferred to that of carbolic acid, as the former does not present the disadvantages of the latter.

(4) Camphorated phenol, when applied to wounds does not irritate them or act as a caustic or disorganizing substance on them, and may be used in large doses, without producing symptoms of poisoning.—*Det. Rev. of Med.*

### Death of Dr. F. E. Anstie, of London.

On September 6th, Dr. Francis E. Anstie wounded a finger of his right hand, in a post-mortem examination of a child who had been a victim of a malignant epidemic. The morning previous to receiving the wound, he spent investigating the causes of the epidemic, greatly exposed to sewer gases. September eighth and ninth he com-

plained of his arm, and poulticed his axilla on the ninth. On the tenth he first called the attention of his medical friends to his condition. He then was confined to bed, with a dry tongue, dry, hot, skin, distressing headache, and much pain over the right pectoral region. On the eleventh Dr. George Johnston (*London Lancet*) says that Dr. Anstie was delirious, tongue dry, temperature 105°, an erysipelatous blush, about the size of the palm of the right hand, over the right pectoral muscle. There was excessive tenderness, on pressure, in the right axilla, and over the front of the chest, on the right side. The slightest movement of the arm elicited a cry of pain. There was no appearance of inflammation about the wound on the hand, or up the arm. On the morning of the twelfth the breathing was very rapid, a distinct friction sound heard over the middle and lower lobe of the right lung, and dullness, on percussion, over the same space. The erysipelatous appearances were unaltered. The urine was highly albuminous, and contained numerous epithelial casts. About the middle of the day symptoms of a blood clot, at the right side of the heart, came on; the features were livid; breathing rapid and shallow; consciousness rapidly lost; and death occurred at half-past 2 P. M. Dr. Anstie was not quite forty-one years old. His life, for the past ten years, was one of the most intense activity. He was editor of the *Practitioner* since its commencement; author of works on "stimulants and narcotics," "neuralgia," and a large number of articles contributed to journals, reviews, year books, etc.—*Detroit Review*.

## Medical Journal.

E. W. SCHAUFLER, M. D., } Editors.  
D. R. PORTER, M. D., }

Kansas City, Mo., NOV., 1874.

### Kansas City District Medical Society.

The first regular quarterly meeting of this Society is to be held at Kansas City, on Wednesday, the 2d day of December, beginning at 10 o'clock A. M. Essays on the following subjects may be expected from the regular appointees, and it is hoped that some volunteer papers and reports of cases will also be forthcoming. Dr. A. L. Chapman, of Kansas City, will write on "Inflammation,—Cystoblastema,—Protoplasm;" Dr. J. T. Marsh, of Liberty, on "Cerebro-Spinal Fever;" and Dr. C. H. Abbot, of Pleasant Hill, on "The Reciprocal Relations of Animal and vegetable Life to the Atmosphere."

### Linton District Medical Society.

The third semi-annual session of this remarkably wide-awake Society is to be held at Fulton, on Tuesday, Nov. 10th, beginning at 3 o'clock P. M., and to continue in session two days. A large and varied programme is laid out. Gentlemen have been appointed to read papers on the following subjects: Scarlatina; Jaundice; The use of the Thermometer in Disease; The use of the Microscope; Hydrate of Chloral; Hysteria; Placenta Praevia; Puerperal Convulsions; Dysentery; Abdominal Tumors; Fractures of the Femur.

We are requested to inform all doctors preparing to attend this meeting, that they should buy round trip tickets, at one and one fifth fare, *on starting*, this being the only way of obtaining commutation of fare. The Secretary of the Society, Dr. J. W. Lanier, of Mexico, informs us that they expect about 200 physicians to assemble at this meeting.

THE President and some members of our District Medical Society having expressed a desire that the Constitution and By-laws of the Society be published in the JOURNAL, for the information of members and those who contemplate becoming such, we gladly give them room.

### CONSTITUTION.

**Sec. 1. NAME.**—This Association shall be called the Kansas City District Medical Society, and its membership shall be composed of physicians living in the counties of Platte, Clay, Ray, Jackson and Cass, and such other counties as may hereafter be added.

**Sec. 2. OBJECTS.**—The purpose of this Society shall be the collection, interchange, preservation and general diffusion of medical knowledge among the profession and throughout the country. It will attempt to direct public opinion in regard to the duties, requirements and responsibilities of medical men, and cultivate fraternal feeling among its members.

**Sec. 3. MEMBERS.**—The members shall be graduates in medicine, in good professional standing, and members of their County Society, where such organization exists.

**Sec. 4. CODE OF ETHICS.**—This Society recognizes the code of ethics of the American Medical Association as binding upon its members.

### BY-LAWS.

**Sec. 1. ELECTION OF MEMBERS.**—There shall

be annually chosen a Committee on Membership, consisting of three. Candidates must be recommended by two members of the Society, one of whom, at least, shall be resident of the county in which the applicant lives.

Application for membership must be made in the hand-writing of the applicant, and when presented shall lie over till the succeeding meeting, the names of candidates being stated upon the notice issued by the Secretary.

All elections to office or membership shall be by separate ballot, and a vote of three-fourths of the members present shall be necessary for an election to membership.

Every member shall sign the Constitution and By-Laws.

**Sec. 2. Officers.**—The officers shall be a President, Vice-President and Secretary ; and their term of office shall be for one year, unless re-elected thereto.

The President shall conduct the meetings of the Society according to usage ; in his absence the Vice-President shall occupy the chair.

The Secretary shall keep the minutes, carry out the intentions of the Society in respect to its transactions, call its meetings, conduct its correspondence, and act as Treasurer and Librarian.

Selection of officers shall take place at the annual meeting.

**Sec. 3. Meetings.**—The Society shall hold its meetings on the first Wednesday of September, December, March and June, at 10 A. M., in Kansas City, Mo. Four members shall constitute a quorum. Notice of the time and place of meeting shall be sent to members by the Secretary.

The Annual Meeting shall be held on the first Wednesday in September, at 10 A. M., at which time an address shall be delivered by the retiring President.

**Sec. 4. Proceedings.**—The proceedings of the Society shall, after having been reported and accepted at the ensuing meeting, be published by the Secretary when so ordered.

##### Sec. 5. ORDER OF BUSINESS.—

- (1) Reading the record of the previous meeting.
- (2) Reception of Strangers.
- (3) Reading of the Secretary's correspondence.
- (4) Report of Committee on Membership.
- (5) Election of new members.
- (6) Exhibition of Instruments or Surgical Apparatus.
- (7) Exhibition of Pathological Specimens.
- (8) Written communications, authorized and voluntary.
- (9) Verbal reports of cases.
- (10) Incidental business.

At Annual Meetings the election of officers and address of the retiring president shall follow imme-

dately after the reading of the record of the previous meeting and the reception of strangers.

**Sec. 6. VISITORS.**—Visiting physicians in good standing shall be welcomed to the floor of the Society, in debate, but will not be allowed the privilege of voting.

**Sec. 7. ASSESSMENTS.**—An annual assessment of two dollars shall be levied on each member for the purpose of defraying the expenses of the Society.

**Sec. 8. EXPULSION OF MEMBERS.**—For violation of its Code of Ethics, any member of the Society may be expelled by a three-fourths vote of the members present, due notice of the charges having been sent to each member, and opportunity being allowed to the alleged offender to clear himself.

Members in arrear of assessment for two years may be stricken from the roll.

**Sec. 9. ALTERATION OF THE CONSTITUTION OR BY-LAWS.**—Propositions to amend or alter the Constitution or By-Laws must lie over to the succeeding meeting before they can be acted upon. A vote of three-fourths of the members present shall be requisite for an alteration of the Constitution, and of a majority of the members present shall be requisite for an alteration of the By-Laws.

## BOOKS RECEIVED.

CLINICAL LECTURES ON DISEASES OF THE NERVOUS SYSTEM. By W. A. HAMMOND, M. D., etc., etc. Edited by T. M. B. Cross, M. D. New York : D. Appleton & Co. 1874.

CRUPO, IN ITS RELATIONS TO TRACHEOTOMY. By J. SOLIS COHEN, M. D. Philadelphia : Lindsay & Blakiston. 1874.

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Graduation Fee . . . . .	30 00

### FEES FOR THE SUMMER SESSION.

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